Oxarart, Scott

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Sent: Thursday, July 1, 2021 9:46 AM
To: Oxarart, Scott
Subject: Saving Lives Together 🔗: Newsletter from the National Center for Fatality Review & Prevention

Saving Lives Together

In the June 2021 edition:

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Greetings from the Staff

Colleagues,

Hello, and happy summer. Our staff at the National Center has a number of things that we are excited to tell you about, including our Virtual National CDR Meeting, building a data visualization query into the National Fatality Review-Case Reporting System (NFR-CRS), an enhanced FIMR Case summary in the NFR-CRS, and new resources to support fatality reviews related to COVID-19. We hope you find them useful.

Gathering as a team has looked different during the COVID-19 pandemic; however, we are ready to help in any way possible.

Thank you for all you do to improve safety for your community and its children.

-Abby Collier

Director

Upcoming Events

Regional FIMR Coordinator Calls

- Western Region (CA, MT, NV, UT, WY): July 14, 2021, 4:00-5:00 PM EDT
- Northern Region (WV, PA, NJ, DE, MD, ME, DC): July 20, 2021, 9:30-10:30 AM EDT
- Midwest Region (MI, WI, OH, IL, IN): July 20, 2021, 11:00 AM- 12:00 PM EDT
- Southern Region (KY, TN, MS, AL, FL): July 22, 2021, 10:00-11:00 AM EDT
- Central Region (CO, NE, KS, OK, TX, MO LA): July 26, 2021, 11:00 AM- 12:00 PM EDT

Field Notes

Washoe County FIMR Identifies COVID-19-Related Barriers to Accessing Prenatal Care

The Washoe County Health District is the home of the only FIMR program in the state of Nevada. With a population of approximately 470,000, including Reno, NV, Washoe County is the state's second-most populous county. "The infant mortality rate for Washoe County is 6.3 deaths per 1,000 live births, a rate that is slightly higher than the state of Nevada at 6.14 deaths per 1,000 live births," said Kelly Verling, public health nurse supervisor. The FIMR case review team reviews approximately 40 cases per fiscal year, which is about 50% of all fetal, neonatal, and post-neonatal deaths in Washoe County.

In 2020, the team found that delayed and/or interrupted prenatal care due to COVID-19 was a serious risk factor for poor pregnancy outcomes. "Some reasons for delayed health seeking were lockdown, lack of understanding of guidelines or resources, and fear of contracting infection," shared Rebecca Gonzales, the FIMR co-coordinator. The FIMR community action team recommended increased activities to advocate for pregnant women during the coronavirus pandemic.

To do this, they promoted access to information for providers and patients to prevent delays in care or lack of care due to concerns about COVID-19 or misinformation about safety procedures. Activities included:

- The Northern Nevada Maternal Child Health Coalition, the acting FIMR community action team, (URL: https://www.nvmch.org/regional-membership/northern-nv-coalition/) provided two presentations about COVID-19 to maternal child health professionals and community members.
- The Nevada Division of Health and Human Services Division of Public and Behavioral Health added more easily accessible information to the COVID-19 information for pregnant women on their website.
- Additionally, provider offices ran public service announcements encouraging women to continue to seek prenatal care during the pandemic.

"In a time of so many unknowns, it is great to see our community come together to advocate for pregnant moms and their families," Gonzales said.
For more information on reviewing cases related to COVID-19, visit the National Center's resource page, under "COVID-19" (URL https://www.ncfrp.org/center-resources/written-products/).

New Kansas Law Facilitates Data Use Innovations

Kansas House Bill 2158 was signed into law by Governor Laura Kelly on May 21, 2021, making significant changes in the way the State Child Death Review Board (URL: https://ag.ks.gov/about-the-office/affiliated-orgs/scdrb) will be able to use confidential fatality review data. Under the bill, Kansas will be able to share fatality review information with county and district attorneys, members of the Legislature in executive session, state licensing agencies in relation to disciplinary complaints, and for de-identified health education research. Kansas will also be able, for the first time, to participate in the National Fatality Review-Case Reporting System (NFR-CRS).

The National Center's director, Abby Collier, provided testimony in a hearing on an original Senate version of the bill (SB 83) on February 2, 2021.

All of the changes support the stated goals of the State Child Death Review Board that sits in the Kansas Office of the Attorney General:

- To describe trends and patterns of child deaths, identifying risk factors in the population;
- To improve inter-agency communication so recommendations can be made regarding recording of actual cause of death, investigation of suspicious deaths, and system responses to child deaths;

- To develop prevention strategies including community education and mobilization, professional training, and changes in legislation, public policy and/or agency practices.

Participants in the NFR-CRS retain ownership of their own data at the state level and determine if and how their de-identified data can be used for research under the terms of their data use agreement with the National Center.

Kansas legislators had attempted to pass a version of this bill through several years' worth of legislative sessions. Congratulations to the State Child Death Review Board and its coordinator, Sara Hortenstine, on this significant achievement that will maximize the impact of child fatality review data in Kansas and beyond.

Virtual Meeting Connects State CDR Coordinators

The National Center hosted a National Virtual CDR Meeting for state CDR coordinators and key program staff on June 16, 2021. Over 120 state CDR staff and national partners joined, focused on the shared mission of helping children celebrate more birthdays.

Highlights of the meeting included:

- Presentation on the national evaluation of CDR implementation, conducted by the Johns Hopkins Center for Injury Research and Policy
- Discussion on accessing records to support effective fatality review
- Data visualization presentations and resources
- Working sessions focused on planning and providing input on regional CDR opportunities and resource development

Thank you to all who participated. The picture above is a word cloud created from the meeting participants' "bucket list" items.

Do you know of an innovative fatality review practice, successful project, partnership, or other activity from a state or local program that the National Center could share in *Field Notes*? We welcome your suggestions at info@ncfrp.org.

Kudos Corner

Veteran Delaware Coordinator Wins National CDR Award

The National Center is thrilled to announce the 2021 winner of the Theresa M. Covington Award for Excellence in Fatality Review, Anne Pedrick. The award was presented at the National CDR Virtual Meeting on June 16th. Anne has been the Executive Director of the Delaware Child Death Review Commission since 2006, also leading implementation of FIMR, and maternal morality review, and leading the efforts to access CDC funding as a member of the Sudden Unexpected Infant Death Case Registry during that time.

Anne has been an active member of the Mid-Atlantic Regional CDR Coalition, offering her knowledge to CDR colleagues in neighboring states and across the country. Some of the efforts she led in Delaware included:

- Convening partners to secure grants from AstraZenaca and Barclay Card to educate parents and reduce risk for abuse head trauma
- Initiating a safe sleep poster contest for middle school students to increase awareness of SUID risk
- Compiling a retrospective 10-year report on child firearm deaths using CDR and hospital data

She has built broad partnerships with Cribs for Kids, Direct On-Scene Education (DOSE), and Cops N' Cribs, using each partner's strengths to help make the kids and families of Delaware safer, healthier, and more protected. **Thank you, Anne, for your contributions to the field of fatality review and for your commitment to the children and families of Delaware!** To learn more about the work of the Delaware Child Death Review Commission, visit: https://courts.delaware.gov/childdeath/.

Annual Award Honors Long-time FIMR Leader in Montgomery County, Maryland

The Montgomery County Improved Pregnancy Outcomes Program (also known as the SQI Program) (URL: https://www.montgomerycountymd.gov/HHS-Program/Program.aspx?id=PHS/PHSImpPreganacyOutcomes-p739.html) has long looked for a way to recognize team members' stellar efforts to reach women of childbearing age with preconception and healthy pregnancy /postpartum messages.

When longtime FIMR Board co-chair Arva Jackson officially stepped down from that role, it presented an opportunity to honor her and also highlight the kind of community work she championed. Thus, the Arva M. Jackson Community Outreach Award was born.

"We are happy to have found a way to honor Arva Jackson," said Montgomery County Health Officer Dr. Travis Gayles. "Many residents here know Arva as a former FIMR Board co-chair and longtime community advocate, but not everyone is aware that her dedication to improving the health and well-being of community members spans more than four decades."

The first-ever recipient of the award was announced during the FIMR Board, Community Action Team & Child Fatality Review Team Annual Data Meeting on June 8, 2021. "This award allowed us to publicly recognize a FIMR Board or CAT member organization that conducted significant outreach to advance FIMR recommendations," said IPO program manager, Sheilah O'Connor. "We were also looking for a way to spotlight efforts that continued in one way or another during the COVID-19 shutdown."

The winner was Holy Cross Health, which encompasses Holy Cross Hospital and the Holy

Cross Health Network (URL: https://www.holycrosshealth.org/). Congratulations to Arva Jackson and Holy Cross Health! The IPO Program looks forward to continuing this award and all it represents for many years to come.

Data Matters

New Section I8, Supplemental Guidance, and MIS-C

I8. COVID-19-RELATED DEATHS

a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following? Check all that apply:
- ☐ None listed below
- ☐ School
- ☐ Daycare
- ☐ Employment
- ☐ Social services (like unemployment assistance, TANF, WIC)
- ☐ Living environment
- ☐ Medical care
- ☐ Mental health or substance use/abuse care
- ☐ Home-based services (non-child welfare)
- ☐ Child welfare services
- ☐ Legal proceedings within criminal, civil, or family courts
- ☐ Other
- ☐ U/K

Describe:

b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order?
○ Yes ○ No ○ U/K
If yes, was the stay at home order in place at the time of the child's death? ○ Yes ○ No ○ U/K

c. Was the child exposed to COVID-19 within 14 days of death?
○ Yes ○ No ○ U/K
If yes, describe:

d. Select the one option that best describes the impact of COVID-19 on this child's death:
- ○ COVID-19 was the immediate or underlying cause of death
- ○ COVID-19 was diagnosed at autopsy or child was suspected to have COVID-19
- ○ COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death
- ○ The birthing parent contracted COVID-19 during pregnancy
- ○ Other, specify:
- ○ COVID-19 had no impact on this child's death
- ○ U/K

e. Did COVID-19 impact the team's ability to conduct this fatality review?
○ Yes ○ No ○ U/K
If yes, check all that apply:
- ☐ Unable to obtain records
- ☐ Team members unable to attend review
- ☐ Remote reviews negatively impacted review process
- ☐ Team leaders redirected to COVID-19 response

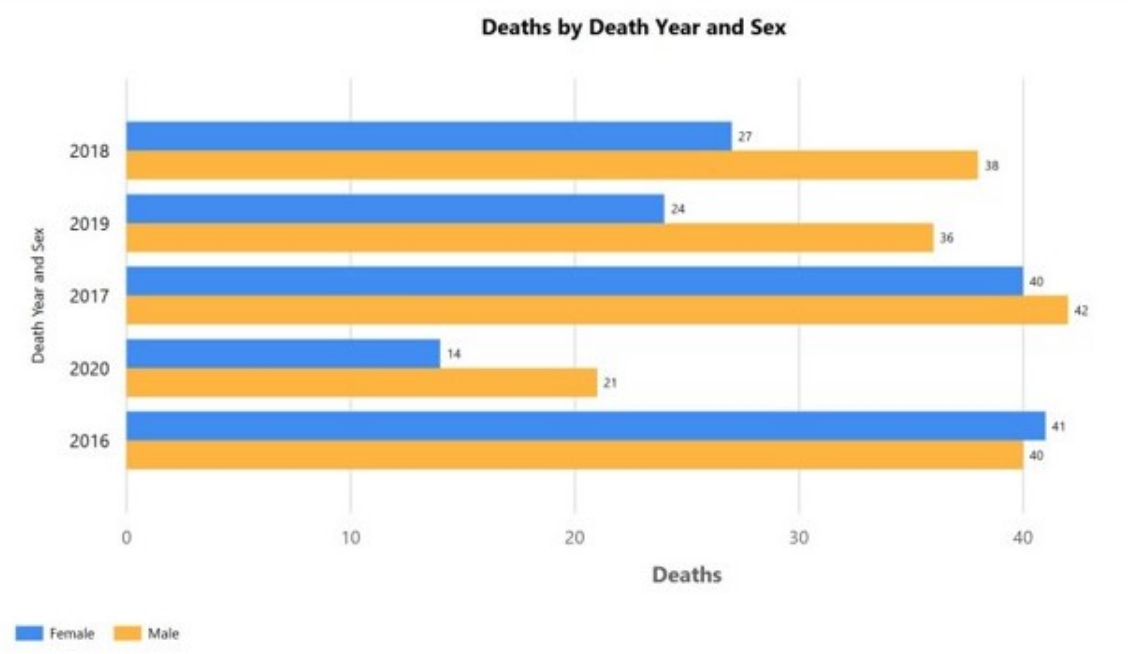
f. Did the child have medical evidence of a significant inflammatory syndrome (including for example, fever, laboratory evidence of inflammation, and involvement of two or more organs) requiring hospitalization in the week before death?
○ Yes ○ No ○ U/K
If yes, was the child diagnosed with MIS-C? ○ Yes ○ No ○ U/K

The National Fatality Review-Case Reporting System (NFR-CRS) rolled out its new section I8 in April, helping teams examine how deaths that occurred during the pandemic may be related, directly or indirectly, to COVID-19. In June, a new question was released examining

if the child may have had a severe inflammatory condition, such as multisystem inflammatory syndrome in children, or MIS-C. Above is the new section I8.

For support in responding to these questions, see the *Introduction and Supplemental Guidance for Section I8-COVID-19 Related Deaths* (URL: https://www.ncfrp.org/wp-content/uploads/Supplemental-Guidance-on-Reviewing-Deaths-During-COVID-19.pdf). The National Center also hosted a webinar in May, *Reviewing and Collecting Data on Deaths During the COVID-19 Pandemic*. It is archived and available here: https://www.ncfrp.org/center-resources/archived-webinars/.
For more information on MIS-C, visit https://www.cdc.gov/mis-c/.

NFR-CRS Reporting Enhancements Coming Soon!



The National Center is excited to announce two new data reporting features coming to the NFR-CRS. The first is a new data querying system called ***Data Explorer.*** With a simple click of some buttons, users will be able to create a customizable query that is unique to their fatality review data. Users can choose to display the output as a bar chart, like the one pictured above, or can select to have the data passed back as individual rows of data with key variables of interest. An example query might be to determine how often death investigations were conducted by manner of death. Another example might be to identify which deaths did not have an autopsy performed, sorted by manner of death. Many filtering options will be available in the query building process. Data Explorer will be available for both CDR and FIMR users.

The second enhancement applies to FIMR users. The National Center is revamping the FIMR Case Summary, which is available on the Manage Cases Action drop-down. Based on feedback from FIMR users, this report will now include many additional fields with better organization of desired output. FIMR users will also have the ability to select which, if any, of the report sections they wish to include in the report.
These two new features will both be released in July. If you have any questions about these enhancements, reach out to the National Center staff at info@ncfrp.org.

New and Departing Coordinators

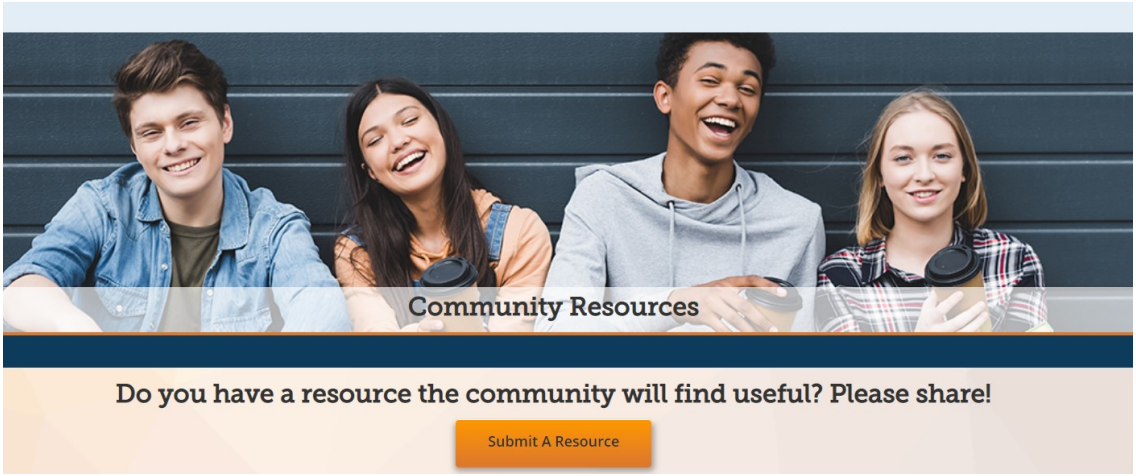
Welcome

- Linzi Horsley, Indiana FIMR
- Kathryn Brice, Maine CAPTA/CJA Coordinator
- Catina Swindle & April Montgomery, State FIMR, Alabama Perinatal Program
- Gabrielle Bargerstock, Flagler & Volusia Counties, FL FIMR
- Kyle Fitzpatrick, San Diego, CA FIMR
- Pam Mullen, Butler County, OH FIMR
- Rose Saldana, Chicago FIMR
- Matthew Orbain, Toledo/Lucas, OH FIMR
- Melissa Moyer, Trish Loughlin, Stefanie Harrington, Jess Wagner, Leigh Ann Holmes, Jackie Bolster, Emily Sayler, Lyn Baughn, Juanita Bueter, Sherrie Marriage, & Keisha Stosich, Montana County FICMMRs

Farewell

- Tina Ferguson, KY SUID Coordinator
- Jan Bielau-Nivus, Maine CAPTA Coordinator
- Dixie Morgese, Flagler & Volusia Counties, FL FIMR
- Julie Rooney, Central MT Health District 1 FICMMR

Resources for Prevention



Fatality Review Community Resources: Sometimes our best resource is each other

While each community is unique, fatality review teams face similar challenges when doing the important and challenging work of reviewing cases of fetal, infant, and child deaths. While the National Center strives to provide useful resources to CDR and FIMR teams, the teams themselves are often best positioned to create useful tools. That is why the National Center has developed the Community Resources portal on its website at https://www.ncfrp.org/community-resources/.

The Community Resources portal is a place where fatality review professionals can identify and access resources developed in other communities and states or submit resources they themselves have developed. Currently, the resources are in one of the following categories:

- Data
- Death scene investigation tools
- Family interviews
- Health equity

- Team process and planning

Check out Community Resources for examples of innovative data reports, jurisdiction-specific and cause-specific death investigation forms, equity trainings, and prevention examples. While you're there, consider what your team may have developed that might be helpful to your colleagues, and click ***Submit a Resource!***

Staff (Not So) Out & About

While National Center staff has not been traveling to engage partners and provide technical assistance during the last year, they have facilitated virtual trainings to diverse partners across the country. Some highlights of the National Center's recent virtual technical support and engagement include:

- Rosemary Fournier presented on FIMR to the Hawaii Collaborative Fatality Review leadership on March 19th.

- Abby Collier presented on *Wellbeing and Self-Care in Fatality Review* for fatality review program coordinators in Indiana on May 10th, including CDR, FIMR, maternal mortality review, and opioid overdose review partners.
- Susanna Joy participated in Tennessee's Annual Child Fatality Review Training on May 12th.
- Rosemary and Susanna worked with the Chicago FIMR Community Action Team on June 21st, helping them prioritize their recommendations for implementation.

If you have a training need, the National Center will be happy to connect with you to find a creative solution and provide technical assistance or training to your program. Reach out to us at info@ncfrp.org!

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The National Center is funded in part by Cooperative Agreement numbers UG7MC28482 and UG7MC31831 from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as part of an award totaling $1,099,997 annually with 0 percent financed with non-governmental sources. The contents of this

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